STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING **02** B. WING _____	**12/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT SOLARBRON THE	**1701 MCDOWELL RD** **EVANSVILLE, IN 47712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code and Environmental Preoccupancy Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a) for the addition of 52 Title 18/19 beds in resident rooms 301 through 313 and 401 through 413 in a new addition. Survey Date: 12/14/15 Facility Number: 010930 Provider Number: 155773 AIM Number: 201274710 At this Life Safety Code and Environmental Preoccupancy Survey, The Terrace at Solarbron was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies, and with 410 IAC 16.2-3.1-19, Environmental and Physical Standards of Indiana's Health Facilities Rules for Comprehensive care facilities in regard to the Life Safety Code and Environmental Preoccupancy Survey for the addition of 52 Title 18/19 beds in resident rooms 301 through 313 and 401 through 413. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 91 and had a census of 34 at the time of this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING **02** B. WING _____	**12/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT SOLARBRON THE	**1701 MCDOWELL RD** **EVANSVILLE, IN 47712**

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K 000	Continued From page 1 All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except a detached maintenance garage used for the storage of maintenance equipment. Quality Review on 12/15/15 by Amy Kelly, LSC Supervisor	K 000		